Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgment before publication.

Adenoma in the Small Bowel

TO THE EDITOR: The case report in the July issue describing carcinoma arising in Crohn disease [Burbige EJ, Bedine MS, Handelsman JC: Adenoma of the small intestine in Crohn disease involving the small bowel] is interesting. However, to add to the value and legitimacy of the case, before it becomes entrenched in the folklore of regional enteritis, documentation of the neoplastic changes would be worthwhile.

The photograph submitted is unconvincing, in my opinion. No pathologist is listed in the case report to lend credibility to the diagnosis. These flaws combine to allow skepticism about an otherwise nice case study.

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Dr. Burbige Replies

TO THE EDITOR: I wish to thank Dr. Mulkey for his comments and commend him for his concern and vigilance.

Unfortunately, it is not always possible to include detailed pathologic material in a simple case report. The case was reviewed by at least two pathologists at The Johns Hopkins Hospital. I will be happy to obtain a slide and forward it to Dr. Mulkey for his review.

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Multiply Injured Patients

TO THE EDITOR: It was with interest that I read the Trauma Rounds' article "Initial Evaluation and Treatment of Multiply Injured Patients" in the May issue. I have become accustomed to reading and learning from Trauma Rounds and appreciate the efforts of Drs. Trunkey and Blaisdell and their staffs in preparing this series. I would like to comment on several aspects of this recent article.

The article described a patient with obvious head, facial and chest, and possible abdominal, injuries who was both hypotensive and tachycardic. It quite appropriately focused on the ABC's of initial management; however, I was bothered by the impression the article gave relative to the management of the airway by orotracheal intubation. I realize a lengthy discussion of decisions that go into the airway management of an acutely injured patient was beyond the scope of this article. but the danger of permanent cervical spinal cord injury while orotracheally intubating a patient with an unstable cervical spine fracture cannot be overstated. I feel strongly that until it can be definitively ascertained by radiographs, patients with evidence of head or facial injuries should be assumed to have a cervical spine fracture and their airway managed by nasotracheal intubation, cricothyroidotomy or Ambu bag and mask. This possibly fatal mistake is too important to be omitted from an article on the management of traumatized patients.

I couldn't agree more that an unstable patient with evidence of thoracic injury should undergo closed tube thoracostomy prior to x-ray.

As to the emergency management of patients in hypovolemic shock secondary to abdominal injury, I would like to relate that our experience with the use of Medical Anti-Shock Trousers (MAST) can be characterized as nothing but

favorable. On multiple occasions (as literature well documents) we have seen a dramatic rise in the systolic blood pressure within moments after the inflation of this suit. While this must not preclude definitive operation, it does in many cases remove patients from shock and maintain them while they are being prepared for laparotomy, thereby avoiding many of the sequelae of the shock state. The use of the MAST can have a net negative effect unless several potential problems are borne in mind. Its use precludes intravenous infusion via the lower extremities and thus necessitates several upper extremity lines; its use markedly elevates the diaphragms, and closed tube thoracostomy must be performed through a higher intercostal space and with much greater care; and perhaps the greatest risk is an unfounded feeling of confidence by the physician resulting in delays in definitive management and underestimation of volume requirements.

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Dr. Trunkey Replies

TO THE EDITOR: I very much appreciated reading Dr. Jergen's letter. The first point, about the awareness of the cervical spinal cord injury, is an excellent one. In fact, in every patient who is in this category at San Francisco General Hospital a lateral cervical spine film is taken before the patient is moved on to the emergency-trauma table. An exception to this is when a patient comes in with cardiac arrest. In that instance, the anesthesiologist usually maintains the patient's head in an axial alignment and moves right along with the intubation.

In regard to the second point, on the use of Medical Anti-Shock Trousers (MAST), I am also in full agreement. We have previously commented on the use of this device in an earlier Trauma Rounds (Lim RC: Abdominal vascular injuries [Trauma Rounds]. West J Med 123:321-324, Oct 1975).

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Pseudoacetylcholine

TO THE EDITOR: Dr. Morris Vilkin's letter to the editor in the July issue is entitled "Grip Test for Pseudoacetylcholine" and discusses patients with "high titre of pseudoacetylcholine." This is physiological nonsense and I am surprised that the editors allowed it to be printed without correction.

There is, of course, no such thing as pseudoacetylcholine. The abnormal sensitivity to succinylcholine found in some patients is due to a genetic deficiency in the plasma cholinesterase enzyme also known as pseudocholinesterase. The "pseudo" prefix is used because it is not the same enzyme as the cholinesterase which is present in nervous tissue and erythrocytes and which is highly specific in its action, the hydrolysis of acetylcholine.

Pseudocholinesterase on the other hand, promotes the hydrolysis of several choline esters including succinylcholine. In its absence, therefore, the action of succinylcholine is greatly prolonged with the resultant syndrome of persisting weakness of respiratory and other muscles.

Dr. Vilkin's grip test may be a valid screening technique for plasma cholinesterase deficiency. But to allow expressions such as "high titre of pseudoacetylcholine" to appear in print in the pages of a scientific journal can only promote confusion and misunderstanding about a subject of considerable importance.

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Health Care Costs

TO THE EDITOR: I usually find the editorials in the WESTERN JOURNAL astute and throught-provoking, but two that appeared in the June 1977 issue had some serious lapses.

In the first editorial, "Health Care Costs—A Call for AMA Leadership," it is stated "In the not too distant future the rising costs of the nation's health enterprise will equal or exceed the portion of the gross national product (GNP) that can be available for this purpose. In the opinion of some responsible persons this will happen when health-related costs reach approximately 9 per-